GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW REGISTRATION APPLICATION
Registration Programs

Please read instructions before completing this form. If you have any questions, call HPLA's toll-free Customer Service line at 1-877-540-5828 Monday through Friday, 8AM to 5PM EST. A charge of $65.00 will be imposed for dishonored checks (public Law 89-208).

SECTION 1. REQUESTED REGISTRATION TYPE/FEES (includes non-refundable application fee – see instructions)

☐ RT – Recreation Therapist by Endorsement $ 230.00

☐ Duplicate Registrations (limit 5) ____X $34.00 = $_____.00

☐ CBC- Criminal Background Check – To schedule an appointment **or see fee schedule** (Call **1-877-783-4187** or www.L1enrollment.com)

Total Enclosed $____.00

Make check or money order payable to DC Treasurer

MAIL TO:
Recreation Therapy Registration
DC Board of Occupational Therapy
P.O. Box 37802
Washington, D.C. 20013

HPLA ONLY		
Check $	Check #	Staff
$ _ _ _ .00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the registration. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

___ – __ – ____
SOCIAL SECURITY NUMBER
If applicant does not provide a social security number, a sworn affidavit is required.

M M D D Y Y Y Y
___ – __ – ____
DATE OF BIRTH

PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

☐ Male ☐ Female
GENDER
Please check the correct box.

SECTION 3. SUPPORTING DOCUMENTS REQUIRED

Please indicate the supporting documents you have included with this package or requested to be sent to the Recreation Therapy Registration. Keep a photocopy of all supporting documents for your records.

		YES	NO	HPLA ONLY
A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	☐	☐	☐
B.	Copy of National Council for Therapeutic Recreation Certification (NCTRC) card.	☐	☐	☐
C.	Completed signed application.	☐	☐	☐
D.	Copies of legal documents supporting all name changes.	☐	☐	☐

SECTION 4. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc .)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc .)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc .)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

SECTION 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4

HOME PHONE NUMBER HOME FAX NUMBER Email Address:

SECTION 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER

SECTION 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an “X” in the appropriate box. This will be the address to which all future registration documents will be mailed. The address that will appear on your registration will be your business address.

☐ HOME ☐ BUSINESS

SECTION 6A. PROFESSIONAL SCHOOLS ATTENDED

List all colleges and universities attended prior to and including professional schools. List in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

SECTION 6B. POSTGRADUATE EXPERIENCE

List all experience since graduation from college, university or professional school, in reverse chronological order, beginning with the most recent. For "Type of Position," use the letter from the key below.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below)*	Full Time	Part Time

* TYPE OF POSITION KEY

A. Employment
B. Private Practice
C. Clinical Rotations
D. Instructor
E. Other (specify on separate sheet of paper)

SECTION 6C. PROFESSIONAL REGISTRATION IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a similar professional registration. You must request and provide verification of licensure for all of these registrations, past and/or present.

Jurisdiction	Date Registration Was First Obtained	Registration Number

SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through J below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this application.

HPLA ONLY

A. Clean Hands Before Receiving a Registration or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your Registration or Permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: Yes ☐ No ☐

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for registration or permit under the Clean Hands Before Receiving a Registration or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

HPLA ONLY: Y ☐ N ☐

			HPLA ONLY
B.	Have you ever been convicted or arrested for a crime (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☐	☐
C.	Are you now or have you ever been registered or licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete Section 6C of this form.)	YES ☐ NO ☐	☐
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐	☐
E.	Have you ever voluntarily surrendered a registration or license after formal charges have been filed against you or while under investigation?	YES ☐ NO ☐	☐
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES ☐ NO ☐	☐
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐	☐
H.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES ☐ NO ☐	☐
I.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your registration, license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES ☐ NO ☐	☐
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) registration or license?	YES ☐ NO ☐	☐

SECTION 8. REGISTRANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

REGISTRANT SIGNATURE	NAME (Please Print)	DATE	HPLA ONLY
			☐

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.